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Politics and policymaking in Medicare Part C

Citation for published version:

Adrion, ER 2020, 'Politics and policymaking in Medicare Part C', *Medical Care*, vol. 58, no. 3, 1256, pp. 285-292. <https://doi.org/10.1097/MLR.0000000000001256>

Digital Object Identifier (DOI):

[10.1097/MLR.0000000000001256](https://doi.org/10.1097/MLR.0000000000001256)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

Medical Care

Publisher Rights Statement:

This is the accepted version of the following article: Adrion, E., 2019, "Politics and Policymaking in Medicare Part C", *Medical Care*, doi: 10.1097/MLR.0000000000001256, which has been published in final form at: https://journals.lww.com/lww-medicalcare/Abstract/publishahead/Politics_and_Policymaking_in_Medicare_Part_C.98358.aspx

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ANNALS OF HEALTH SERVICES RESEARCH:
POLITICS AND POLICYMAKING IN MEDICARE PART C

ABSTRACT

Background: Once just a small part of the Medicare program, private managed care plans now cover over one-third of all Medicare beneficiaries and cost the Federal government approximately \$210 billion each year. Importantly, the evolution of Medicare managed care policy has been far from linear; for several decades there have been dramatic shifts in the payment and regulatory policies facing private Medicare managed care plans.

Objectives: This article presents a critical review of the history of Medicare managed care payment and regulatory policies and discusses the role of political ideology and stakeholder influence in shaping the direction of policy over time.

Conclusions: As Medicare Advantage becomes an increasingly prominent area of focus for the health services, health policy, and medical research communities, it is important to bear in mind the highly political history of the program, the role of stakeholder influence in shaping the direction of policy, and to understand the historic barriers to evidence-based policymaking.

Key words: Medicare Advantage, health insurance, health policy

INTRODUCTION

Since the passage of the Social Security Amendments of 1972, Medicare beneficiaries have been able to choose between participating in the traditional fee-for-service Medicare program, or enrolling in a private Medicare managed care plan.¹ Under traditional Medicare, the government reimburses private providers directly. In contrast, under Medicare Part C – also known as Medicare Advantage, Medicare managed care, or (previously) Medicare+Choice – private health insurance plans receive monthly capitation payments from the Federal government to provide Medicare Part A and B benefits to enrollees (Table 1). Though initially a small part of the Medicare program, over one-third of Medicare beneficiaries are now enrolled in private plans.²

Over time, there have been substantial shifts in the payment and regulatory policies facing Medicare managed care plans. The political rhetoric around Part C would suggest that Republicans generally support higher payments and looser regulation of private insurers as a means to encourage participation in Medicare and enhance beneficiary choice. Democrats, in contrast, have often argued that managed care plans should be required to be more efficient than traditional Medicare, and thus should be able to operate at a lower cost. While these themes do emerge throughout the history of Part C, policymaking in this area has not always aligned quite so clearly with these values. As Ted Marmor noted nearly two decades ago, Part C policy has been driven by a “complicated combination of politics, policy and circumstance.”³ This largely holds true today.

A key policy challenge lies in squaring the program’s conflicting objectives, including reducing Medicare spending, increasing choice, and offering better health care

benefits to older adults. However, the political conversation around Part C has rarely involved an evidence-based discussion of the policies needed to balance these conflicting objectives. As Medicare Advantage becomes an increasingly prominent area of focus for the health services, health policy, and medical research communities, an understanding of the history and evolution of policymaking in this area – and the limited role that evidence has played in policy development – is essential. This article presents a critical examination of the history of Medicare managed care payment and regulatory policy and discusses the role of political ideology and stakeholder influence in shaping the direction of policy over time.

POLICY BACKGROUND: PART C PAYMENT POLICY FROM 1982-2019

The Early Years: 1982-1997

When the prospective payment program for private plans in Medicare was first introduced following passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982, the motivation was unmistakably to reduce Medicare spending; the decision to set the reimbursement rate for plans at 95% of expected costs in traditional Medicare represented a concerted effort to reduce per-beneficiary costs by 5%.¹ This policy was part of a larger effort by the Reagan Administration to cut overall Medicare spending. Indeed, another major prospective payment program - diagnosis-related group (DRG) payments for hospital inpatient services under traditional Medicare – was introduced in 1983.⁴ However, whereas per-beneficiary spending on Part A hospital services declined following the introduction of DRGs,⁵ the prospective payment program for private plans proved less successful. With inadequate risk adjustment mechanisms in place, and a

pattern of favorable selection into private plans, Medicare's prospective payments to insurers actually exceeded per-enrollee health care costs. Thus, rather than being cost-saving, the first prospective payment program ended up costing Medicare 5.7% more per private plan enrollee.⁶

These extra payments, in combination with the ability of private plans to control costs through restricted provider networks and stringent managed care mechanisms such as pre-authorization requirements for care, meant that, in the years following the implementation of the prepaid payment program, private plans were increasingly able to offer enhanced benefits – including prescription drug coverage, which was not a standard benefit at the time – and lower premiums to enrollees.⁶ These enhanced benefits attracted greater numbers of beneficiaries to private plans. In the seven years from 1990 to 1997, enrollment grew from 3.5% to 13.5% of all Medicare beneficiaries.⁷ However, the overall costs to Medicare grew as well, counteracting the original purpose of the prospective payment program.

Attempted Cost Control: 1997-2003

In the late 1990s, it became increasingly clear that managed care plans were a key source of rising costs in the Medicare program. There was already significant pressure on policymakers to stem the growth in Medicare spending following the 1995 Medicare Trustee Report, which described the Hospital Insurance Trust Fund as in need of “prompt, effective, and decisive action”.⁸ Newly reelected Democratic President Bill Clinton and the Republican-controlled House and Senate battled behind the scenes to agree upon policy solutions to address rising Medicare spending. The result – the

Balanced Budget Act of 1997 (BBA) – represented a delicate balance of diverse interests. The BBA simultaneously expanded the types of private plans eligible to participate in Medicare (including private fee-for-service (PFFS) plans and Medical Savings Accounts), while specifically targeting spending on private plans, reducing the annual updates to plan payments in an effort to level the playing field with traditional fee-for-service Medicare.⁹ In his remarks upon signing the BBA into law, Clinton focused exclusively on the cost containment objective of Medicare managed care, stating that the BBA “honors our commitment to our parents by extending the life of the Medicare Trust Fund for a decade.”¹⁰

Following the passage of the BBA, private insurers began lobbying Congress, arguing that the severity of the payment reductions would no longer allow them to offer the level of enhanced benefits that kept beneficiaries enrolled in their plans. Eventually, Congress eased up on some provisions by introducing new legislation that increased payments in certain geographic areas through the Balanced Budget Recovery Act of 1999 and the Benefits Improvement and Protection Act of 2000.^{9,6}

Despite these policy changes, pressure from insurers continued to mount over time, and some plans exited the Medicare market entirely.⁷ Over this period, enrollment in private plans fell from a high of 18% of all Medicare beneficiaries in 1999 to just 13% in 2003 (Figure 1).

The Pro-Competition Era: 2003-2007

In late 2003, just over two years into his first term, Republican President George W. Bush, along with a Republican-led Congress, passed the Medicare Prescription Drug,

Improvement and Modernization Act (MMA). Although the introduction of the Part D prescription drug benefit was the most widely publicized feature of the law, the MMA, which renamed Part C “Medicare Advantage”, also introduced a new benchmark-based bidding system for Medicare managed care plans, and included provisions that dramatically increased payments to plans, in what was viewed as a concerted effort to expand the role of the private sector in Medicare.¹ In his remarks upon signing the MMA into law, President Bush addressed Medicare managed care at length:

In addition to providing coverage for prescription drugs, this legislation achieves a second great goal. We're giving our seniors more health care choices so they can get the coverage and care that meets their needs [...] And when seniors have the ability to make choices, health care plans within Medicare will have to compete for their business by offering higher quality service. For the seniors of America, more choices and more control will mean better health care.¹¹

There is a clear emphasis on choice and expanded benefits in this address, and along these lines, the MMA has since been described as a law that “exemplified the politics of benefit expansion rather than that of cost control”.¹²

Following the passage of the MMA, the number of Medicare managed care contracts grew substantially, and an unprecedented number of Medicare beneficiaries enrolled in private plans: enrollment sky-rocketed to 9.7 million, or over 20% of all Medicare beneficiaries by 2008 (Figure 1).¹³ The extra benefits available to enrollees also expanded. It was no longer the case that only the most efficiently managed plans offered enhanced benefits; the massive increases in payments ensured that nearly all plans offered benefits above what was offered through traditional Medicare.¹⁴ The new rhetoric around Medicare Advantage (MA) was not about efficiency or cost containment, it was about expanded benefits and health plan choices.

Democratic Rule: 2007-2010

In 2007, political tides began to shift yet again as the Democratic Party gained a majority in the House and Senate. By 2008, the extra payments to MA plans resulting from the MMA were costing Medicare an estimated \$8.5 billion annually.⁷ Again pushing for cost containment, Democrats proposed new legislation – the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) – that would phase out a duplicative payment for Indirect Medical Education (effectively lowering payments to MA plans) and placing new regulations on the highly profitable, indemnity-style PFFS plans, including provider network requirements.¹⁵ The MIPPA was passed in both the House and Senate by July 9, 2008. President Bush subsequently vetoed the MIPPA, though Congress overrode the veto and the MIPPA became law on July 15, 2008.¹⁶

The MIPPA had a notable impact on PFFS plans, with many insurers ultimately withdrawing these options from the market following the introduction of the new regulations. While the impact can be seen via a decline in the total number of MA contracts in subsequent years, little impact was seen on enrollment at the time (Figure 1), with many PFFS enrollees transferring into other types of MA plans.

Medicare managed care payments were dramatically restructured once again when Democratic President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law in 2010. The ACA included a number of provisions impacting private plans. These provisions included, beginning in 2012, the implementation of a gradual reduction in benchmark rates to levels as low as 95% of average fee-for-service Medicare costs in counties that ranked in the top quartile for fee-for-service Medicare

spending, and as high as 115% of average fee-for-service Medicare costs in counties that ranked in the bottom quartile of fee-for-service Medicare spending. These reductions, aimed at leveling the playing field both between private plans and traditional Medicare, and across counties within Medicare Advantage, were to be phased-in over a period of two to six years, depending on the size of the reduction in each county.¹⁷

The ACA also outlined a new system of quality-related bonuses that were designed to adjust benchmark rates according to each plan's quality rating. This ACA provision was to be implemented beginning in 2012, however, prior to its implementation, the Centers for Medicare and Medicaid Services (CMS) introduced a quality bonus payment demonstration of their own, superseding the ACA provision. This CMS demonstration effectively modified the bonus system outlined under the ACA by expanding the bonuses to more plans – including those with lower quality ratings – and increasing the size of the bonuses. The CMS demonstration provided an additional \$10.9 billion to plans beyond what was outlined under the ACA between 2012-2014.¹⁸ At the time, many viewed the CMS quality bonus demonstration largely as an effort to take some of the sting out of the benchmark rate reductions in order to appease plans and stabilize the market.

In addition to changing the way that county benchmark rates are calculated, the ACA included provisions that modified the rebate system. Since 2006, private plan payments have been based on a county-level benchmark rate, against which plans submit bids representing the cost to provide Part A and B services to enrollees. If a plan's bid is below the county-level benchmark, a portion of the difference between the plan bid and the benchmark is returned to the plan in what is referred to as a rebate. Prior to the

passage of the ACA, plans received 75% of the difference between their bid and the benchmark in the form of a rebate (with the remaining 25% returned to CMS).⁷ Under the ACA legislation, however, plans with lower quality ratings now receive rebates of just 50% of the difference between their bid and the benchmark; plans with higher quality ratings receive up to 70% of the difference.^{17, 19}

Recent Policy Changes: 2019

On October 3, 2019, Republican President Donald Trump announced his *Executive Order on Protecting and Improving Medicare for Our Nation's Seniors*.²⁰ Intended as an explicit response to “Medicare for All” proposals, the Executive Order directly promotes expanded plan choice and benefit flexibility. The notion of leveling the playing field between MA and traditional Medicare emerges once again, but in this case in reverse, with Sec.3 (a) (iii) proposing actions to “ensure that, to the extent permitted by law, FFS Medicare is not advantaged or promoted over MA with respect to its administration” and Sec.3 (b) proposing identification of options “to inject market pricing into Medicare FFS reimbursement.”²⁰

PAYMENT POLICY AND THE ROLE OF THE INSURANCE INDUSTRY

As outlined above, Medicare managed care policy has shifted numerous times over the past three decades. However, this has not been the sole result of pressure exerted by politicians; insurers have also had a lot to say about – and a lot of say in – changing payment rates and regulatory policies. The insurance industry depends heavily upon Medicare Advantage (MA) as a major source of profits; one quarter of all UnitedHealth

Group profits and as high as two-thirds of Humana's profits reportedly came from MA products in 2014.²¹ As the MA program has grown over time, the stakes for insurance companies have grown ever greater as well, and as such, lobbying efforts by insurance industry representatives have expanded.

Each spring, CMS announces proposed benchmark rates for private plans participating, or contemplating participation in the MA program for the following year. Over the last decade, these announcements have ignited heated political debate around plan payment policy.

In the years immediately following the passage of the ACA, scheduled cuts to MA payments became quite contentious. Because CMS has broad administrative power over MA plan payments, they are entitled to make modifications to payment rates beyond what is outlined in the ACA.²² The insurance industry has capitalized on this by putting intense pressure on Presidents Obama and Trump, as well as members of Congress, to sustain the level of payment generosity that plans became accustomed to under the MMA.

As a key example, the pressure exerted by the insurance industry led the Obama Administration to shy away from some of the same proposed cuts that they once trumpeted. In December 2008, then President-elect Obama gave a briefing on his proposal to reform health care, one of his key campaign platforms. When asked how he might fund such a proposal, he mentioned MA specifically, responding:

We're also going to examine programs that I'm not sure are giving us a good bang for the buck. The Medicare Advantage program is one that I've already cited where we're spending billions of dollars subsidizing insurance companies for a program that doesn't appreciably improve the health of seniors under Medicare.²³

However, the Obama Administration (and by extension, CMS) later backed off on ACA-scheduled cuts to MA payments numerous times, arguably due at least in part to intense pressure from the insurance industry. The industry lobbying group America's Health Insurance Plans (AHIP) was particularly active over this period, publishing press releases and reports warning that even minor reductions in plan payments would have a major impact on enrollees' coverage.^{24,25} At the same time, AHIP worked to mobilize Medicare beneficiaries via their 'Coalition for Medicare Choices' group, releasing dramatic print and television advertisements with messaging that MA rate cuts would reduce benefits and cause MA enrollees to pay substantially more for their MA coverage.²⁶

AHIP's efforts were highly effective: In early 2013, CMS announced a preliminary plan to cut MA payments by 2.2% in 2014, but after intense lobbying from AHIP/the Coalition for Medicare Choices, payment rates ended up being raised by 3.3%.²⁷ Similarly, in early 2014, CMS announced proposed payment cuts of 1.9% for 2015.²¹ With the 2014 midterm elections approaching, many Democrats, fearful of alienating an important voting bloc, joined their Republican counterparts in protesting the cuts. A February 14th, 2014 letter to then-CMS Administrator Marilyn Tavenner signed by a bipartisan coalition of 40 senators – including Ed Markey (D-MA) and Chuck Schumer (D-NY) – stated,

MA has been a great success and should remain a competitive choice for our constituents. Unfortunately, continued regulatory changes that affect the program's funding year after year create disruption and confusion among beneficiaries who are looking for consistency and predictability. [...] Funding stability is key to building upon MA's successful coordinated care health outcomes. We urge you to maintain payment levels that will allow MA beneficiaries to be protected from disruptive changes in 2015.²⁸

Here, the issues of cost containment and efficiency are being sidelined in favor of an emphasis on beneficiary choice and quality of care, and particularly, how both would be greatly diminished without a continuation of the enhanced payments plans receive.

Ultimately, payments to plans were not cut, but instead were raised 0.4% for 2015.²¹

This pattern has largely continued over time, most recently with payment rates scheduled to rise 2.53% in 2020, up from the 1.59% increase initially proposed by CMS in February 2019.²⁹

EMPIRICAL EVIDENCE The body of literature relating to Part C raises important questions around current payment policies, and calls into question the extent to which the purported goals of the program – expanded choice, better healthcare benefits and increased efficiency – are actually realized.

Expanded choice is often cited as a central objective of Part C. Choice in this context refers nearly exclusively to choice of health plan, as the restricted provider networks characteristic of Part C often mean that provider choice is far more limited than within traditional Medicare. Importantly, the literature suggests that the benefits of plan choice may not manifest in reality: studies indicate both that beneficiaries struggle with the task of comparing and choosing between Part C plans,³⁰ and that seniors generally prefer not to change plans, even when doing so may mean better benefits and lower costs.³¹

A second objective of Part C is to provide better healthcare benefits to beneficiaries. Beyond the considerable equity implications of making better benefits available only to those enrolled in private plans, some studies have raised questions

around whether the bidding process and system of rebates is the most efficient means of providing these extra benefits to enrollees. Evidence suggests that somewhere between just one-eighth to half of payment increases were passed on to enrollees in the form of improved benefits and lower premiums.^{32,33} In addition, considerations around quality arise as well. The ACA provisions awarding bonuses to plans for achieving higher quality ratings seem to have had important unintended consequences: MedPAC reports that the new quality incentives have generated serious concerns around star ratings gaming, wherein insurers merge and consolidate plans and contracts to achieve higher ratings.²

Efficiency is another central goal. Plan payments have fluctuated from 95% of costs under traditional Medicare in the 1980s to 113% in the 2000s.³⁴ Payment increases enacted by Congress were historically justified as a key means of encouraging insurer participation in Medicare;³⁴ payment cuts, on the other hand, have often ignited fears of market withdrawal.³⁵ However, the literature going back decades suggests not only that the association between payment rates and insurer participation may not be as strong as the rhetoric might imply, but that there are a number of other factors that have had a strong (and sometimes stronger) influence on insurer participation (Table 2). These studies call into question much of the political rhetoric around Part C payment policy.

In recent years, additional efficiency concerns have emerged. Current payment methodology incorporates risk adjustment mechanisms that provide larger payments for sicker enrollees. While this policy was initially intended to increase efficiency by reducing “cream-skimming” (i.e. targeted enrollment of healthier patients), the patient risk scores upon which risk adjusted payments are based have risen dramatically in recent years, suggesting plans may exaggerate risk scores for financial gain.³⁶ While CMS does

audit risk scores, the number of audits has been low. Fraudulent risk scores cost an estimated \$9 billion annually.³⁶

IMPLICATIONS

The history of private plans in Medicare paints a picture of a policymaking process influenced by political ideology and insurance industry interests. In the political sphere, rhetoric around the impact of Medicare managed care policy has typically been shaped by deeply entrenched beliefs regarding efficiency, competition, and the role of government in health care.

The existing literature suggests that policymakers need to develop a more nuanced and evidence-based approach to policymaking. However, this is an area in which stakeholder influence seems to have often outweighed empirical evidence in shaping the direction of policy. As researchers, our approach to the analysis of Medicare managed care policy is often an apolitical examination of policy design divorced from the political reality in which the policy was created. Yet failing to confront the fact that these policies exist within a complex political context will ultimately result in research that has little lasting impact. Medicare managed care payment and regulatory policy is, and will continue to be, an increasingly important area for further research. However, it is perhaps equally important to advance our understanding of the ways in which we, as researchers, can expand the impact of empirical evidence and support greater adoption of evidence-based policies moving forward.

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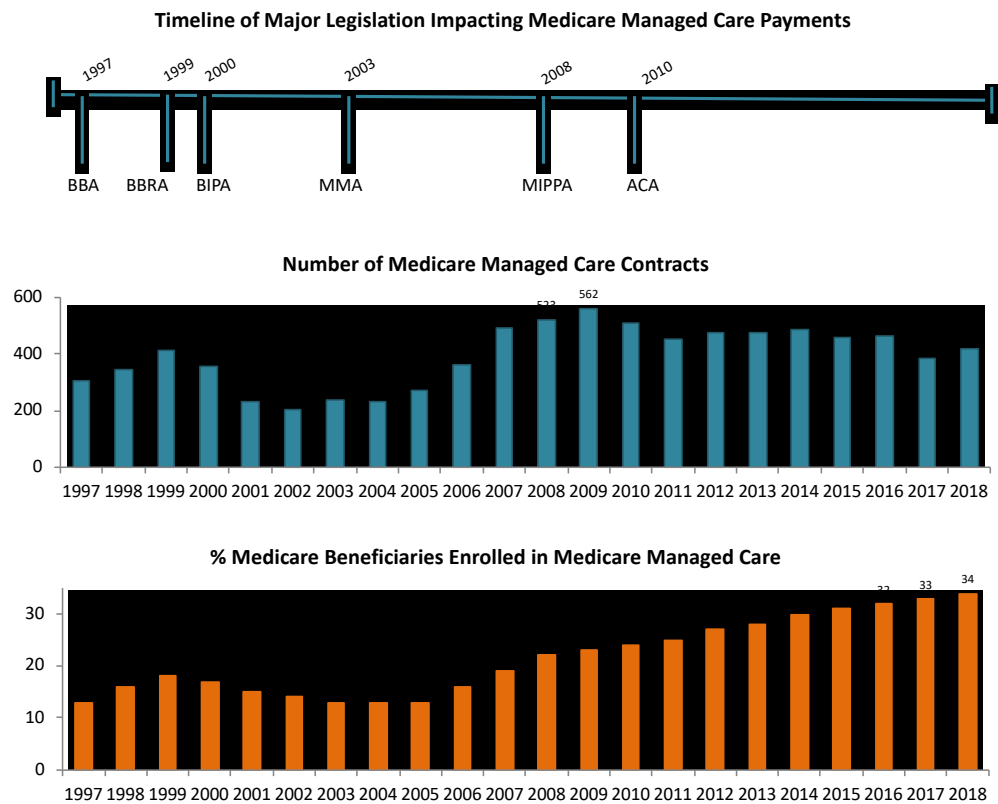
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Figure 1. Medicare Managed Care Enrollment and Contracts, 1997-2018



Notes:

BBA: Balanced Budget Act (1997)

BBRA: Balanced Budget Recovery Act (1999)

BIPA: Benefits Improvement and Protection Act (2000)

MMA: Medicare Prescription Drug Improvement and Modernization Act (2003)

MIPPA: Medicare Improvements for Patients and Providers Act (2008)

ACA: Patient Protection and Affordable Care Act (2010)

Source: Author's analysis of data from Kaiser Family Foundation State Health Facts: Medicare. Available at: <https://www.kff.org/state-category/medicare/medicare-advantage/> Accessed 19 June 2019.

Table 1. Primer: Traditional Medicare versus Medicare Part C

	Traditional Medicare	Medicare Part C
Eligibility	Adults 65 years and older, those with a permanent disability, amyotrophic lateral sclerosis (ALS) or end-stage renal disease.	Same as under traditional Medicare.

Financing	<ul style="list-style-type: none"> Part A: Earmarked payroll taxes go into the Hospital Insurance Trust Fund Part B: General tax revenue, enrollee premiums Part D: General tax revenue, enrollee premiums 	<ul style="list-style-type: none"> A combination of payroll taxes, general tax revenue and enrollee premiums.
Covered services	<ul style="list-style-type: none"> Part A: Hospital Coverage (inpatient care, skilled nursing facility, home health care, etc.) Part B: Medical Coverage (physician and other providers' services, outpatient care, durable medical equipment, etc.) 	<ul style="list-style-type: none"> All services covered under traditional Medicare Parts A and B Some plans may offer additional benefits, including dental and vision care, wellness and other services. Beginning in 2020, plans can offer non-medical services, such as meal delivery.¹
Services not covered	Uncovered services include (but are not limited to) dental, hearing and vision care, long-term care.	Varies by plan.
Out-of-pocket costs	<p><i>Premiums</i>²</p> <ul style="list-style-type: none"> Part A: free for those eligible for Social Security benefits, \$437/month for those not eligible Part B: monthly premium of \$135.50-\$460.50 in 2019 (varies by income) <p><i>Copayments, Coinsurance and Deductibles</i></p> <ul style="list-style-type: none"> Health care services provided under Parts A and B involve standardized out-of-pocket spending for all beneficiaries (e.g. \$1,364 Part A deductible, \$185 Part B deductible, 20% coinsurance for Part B services, etc.)² There is no limit on total annual out-of-pocket spending. Many beneficiaries purchase additional Medigap coverage or have "wraparound" coverage through a retiree plan or Medicaid in order to cover some of the out-of-pocket costs 	<p><i>Premiums</i></p> <ul style="list-style-type: none"> Standard Part B monthly premium of \$135.50-\$460.50 in 2019 (varies depending on income). Some plans charge an additional monthly premium on top of the Part B premium. Some plans have no additional premium on top of the Part B premium. Some plans have no additional premium and may also pay a portion of the Part B premium. <p><i>Copayments, Coinsurance and Deductibles</i></p> <ul style="list-style-type: none"> Copayments, coinsurance and deductibles vary across plans and may vary within each plan from one year to the next. Plans are required to limit total annual out-of-pocket spending on Part A and B services to \$6,700. This applies to services provided by in-network providers only.³

	<p>associated with traditional Medicare and to cover additional benefits.</p> <ul style="list-style-type: none"> • In 2016, the average beneficiary spent \$5,608 out-of-pocket.³ 	
Physician choice	<ul style="list-style-type: none"> • Any provider willing to accept Medicare patients. • No referrals required for specialist services. 	<ul style="list-style-type: none"> • Plan design varies, but generally choice of providers is constrained via fixed provider networks. There are additional out-of-network fees associated with care provided by non-network providers. • Some plans have additional restrictions, such as pre-authorization requirements and/or referral requirements for specialist care.
Provider reimbursement	<ul style="list-style-type: none"> • Part A: Diagnosis-related groups • Part B: Fee-for-service reimbursement based on Medicare fee schedules determined via the resource-based relative value scale.⁴ • Following various reforms, some payments under Part A and B are now linked to patient outcomes, care quality and/or value. 	<p>Provider payment rates are negotiated privately between insurers and health care providers and vary across insurers/plans.</p>
Interaction with Part D prescription drug coverage	<p>Standalone Part D coverage must be purchased separately.</p>	<ul style="list-style-type: none"> • Part D coverage (and the associated premium) may be included in the MA plan and MA premium (referred to as MA-PD plans). 88% of MA plans include Part D benefits.⁵ • Some MA plans do not cover Part D benefits and require separate purchase of standalone Part D coverage.

¹ Neuman P, Jacobson GA. (2018) Medicare Advantage Checkup. NEJM. 379(22): 2163-2172.

² Medicare.gov. Medicare costs at a glance. <https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance> Accessed 30 September 2019.

³ Kaiser Family Foundation. An Overview of Medicare. The Henry J. Kaiser Family Foundation; 2019. Available at: <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>

⁴ Centers for Medicare and Medicaid Services. Fee Schedules - General Information. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html> Accessed September 27, 2019.

⁵ Kaiser Family Foundation. Fact Sheet: Medicare Advantage. The Henry J. Kaiser Family Foundation; 2017. Available at: <http://files.kff.org/attachment/Fact-Sheet-Medicare-Advantage>

Table 2. Key Research Regarding Medicare Managed Care Plan Participation

Reference	Study period	Key findings
Adamache KW and Rossiter LF. The entry of HMOs in the Medicare market: Implications for TEFRA's mandate. <i>Inquiry</i> . 1986; 23(4): 349-364.	1982	An increase in plan capitation rates of one standard deviation above the mean was associated with an 8% increase in the probability of market participation.
Porell FW and Wallack SS. Medicare risk contracting: Determinants of market entry. <i>Health Care Financing Review</i> . Winter 1990; 12(2): 75-85.	1986	Higher payment rates, greater Medicare managed care market concentration and lower market share in the non-Medicare managed care market were all associated with a greater probability of plan participation.
Abraham J, Arora A, Gaynor M, and D Wholey. "Enter at Your Own Risk: HMO Participation and Enrollment in the Medicare Risk Market," <i>Economic Inquiry</i> , 2000, 38(3): 385-401.	1990-1995	A \$35 increase in a plan's monthly capitation rate was associated with a 3% increased probability of market participation. Certain demographic factors, including the age structure of the population in a given market (proportion of the population 65-75 years and proportion of the population 75+ years), were also found to be associated with plan participation.
Pai CW and Clement DG. Recent Determinants of New Entry into a Medicare Risk Contract: A Diversification Strategy. <i>Inquiry</i> . Spring 1999; 36(1): 78-89.	1995	Higher payment rates and overall growth in managed care enrollment were statistically significantly associated with an increased probability of a new plan entering a market
Brown RS and Gold MR. What Drives Medicare Managed Care Growth? <i>Health Affairs</i> . November/December 1999; 18(6): 140-149.	1996-1997	Key market characteristics associated with plan participation include payment rates, historic presence of non-Medicare managed care in the area, proportion of the over-65 population with Medicaid or employer-subsidized coverage, and presence of large physician groups in the county. Wide variation in capitation rates across counties led some plans to selectively offer plans in only those counties with higher rates.
Glavin MPV, Tompkins CP, Wallack SS and Altman SH. An Examination of Factors in the Withdrawal of Managed Care	1998	A decrease in the average payment rate equal to one standard deviation below the mean increased the probability of a plan exiting the market by nearly 8 percent. Plans with for-profit status and lower market

Plans from the Medicare+Choice program. Inquiry. Winter 2002/2003; 39(4): 341-354.		share had a significantly higher predicted probability of exiting the market.
United States General Accounting Office. <i>Many Factors Contribute to Recent Withdrawals; Plan Interest Continues</i> . (GAO 99-91). Washington, DC; 1999.	1999-2001	Newer plans, plans with fewer enrollees, plans that struggled to establish adequate provider networks, and plans locating in areas with larger competitors were more likely to exit the market following the implementation of the BBA.
United States General Accounting Office. <i>Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings</i> . (GAO 00-183) Washington, DC; 2000.		
United States General Accounting Office. <i>Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001</i> . (GAO 02-202) Washington, DC; 2001.		
Halpern R. M+C Plan County Exit Decisions 1999-2001: Implications for Payment Policy. Health Care Financing Review. Spring 2005; 26(3): 105-123.	1999-2001	The introduction of payment floors in the BBA (which increased plan payments in areas with lower average fee-for-service costs) was significantly associated with a lower likelihood of a plan exiting a county.
Cabral M, Geruso M, Mahoney N. Do larger health insurance subsidies benefit patients or producers? Evidence from Medicare Advantage. American Economic Review. 2018; 108(8): 2048-87.	1997-2003	Among plans receiving higher payments via the introduction of payment floors, only around half of those higher payments were passed on to enrollees in the form of reduced premiums (45%) and additional benefits (9%).
Hurley RE, Strunk BC and Grossman JM. Geography and Destiny: Local-Market Perspectives on Developing Medicare Advantage Regional Plans. Health Affairs. July/August 2005; 24(4): 1014-1021.	2004	The ability to selectively enter counties with higher payment rates viewed as a key factor enabling MA plans to be profitable. Provider consolidation, local health system capacity and health plan leverage in negotiating provider contracts were other important factors.
Frakt AB, Pizer SD and Feldman R. Payment Reduction and Medicare Private Fee-for-Service Plans. Health Care Financing	2001-2008	A reduction in MA benchmark rates to 100 percent of average fee-for-service costs would reduce private fee-for-service plan market entry by 85 percent.

Review. Spring 2009; 30 (3): 15-24.

Song Z, Landrum MB, Chernew ME. Competitive bidding in Medicare Advantage: Effect of benchmark changes on plan bids. Journal of Health Economics. December 2013. 36(6): 1301-1312	2006-2010	Plan bids rise as benchmark rates increase: An increase in county benchmark rates of \$1 was associated with a \$0.53 increase in plan bids.
Duggan M, Starc A, Vabson B. Who benefits when the government pays more? Pass-through in the Medicare Advantage program. J Public Econ 2016; 141: 50-67.	2007-2011	Only about one-eighth of reimbursement increases to MA plans over the study period was passed on to MA enrollees through expanded coverage.
Afendulis CC, Landrum MB, Chernew ME. Impact of the Affordable Care Act on Medicare Advantage Plan Availability and Enrollment. Health Services Research. December 2012. 47(6):2339-2352	2010-2011	Counties expected to receive the lowest payment rate increases or payment rate reductions following the ACA experienced a greater decrease in the number of plans offered. No similar relationship at the contract level was found.
Pelech D. Paying more for less? Insurer competition and health plan generosity in the Medicare Advantage program. Journal of Health Economics. 2018; 61: 77-92.	2007-2012	Reductions in county-level plan offerings (PFFS plans) following the MIPPA were associated with an increase in expected enrollee out-of-pocket spending and higher premiums for PFFS plans.
Layton TJ, Ryan AM. Higher Incentive Payments in Medicare Advantage's Pay-for-Performance Program Did Not Improve Quality But Did Increase Plan Offerings. Health Services Research. December 2015. 50(6):1810-28.	2009-2014	Double bonus payments under the Medicare Quality Bonus Payment Demonstration were associated with a 5.8 percent increase in the number of plans offered in a county.
